TENNESSEE
DEPARTMENT OF CHILDREN'S SERVICES

CHILD DEATH REVIEW
ANNUAL REPORT 2014

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Acknowledgement

The Tennessee Department of Children's Services Office of Child Health wishes to acknowledge the many professionals, volunteers and community partners whose commitment and support to Child Death Review has made this process possible.

It is important to note the CDR process does not exist to identify individual culpability in any death or near death event. The CDR process exists to best explain the inherently complex nature of child welfare work and the many factors which influence decision-making. These decisions alone are rarely direct causal factors in a child's death or near death; but, these decisions may affect the overall trajectory of well-being for a child or family and be an influence, among many influences, of poor outcomes. The CDR process makes every effort to be a safe and supportive environment for staff to process, share and learn from child deaths and near deaths in an effort to best support quality case management practices and influence increasingly safe outcomes for children.

Executive Summary

A comprehensive and thorough child death review process is a critical component of any child welfare agency. The review provides an opportunity for agencies to examine their systems of safety. While typically there are assumptions that deaths and near deaths are caused by isolated failures of people or processes, it is largely not the case. Rather these tragic and usually unforeseeable events emerge from a complex social system comprised of society, communities, health agencies, cultures, public agencies and families working to support safe outcomes.

The Department of Children's Services (DCS or the Department) is charged with providing supports to vulnerable children and families in this complex social system affected by significantly challenging issues such as poverty and substance use. Child welfare agencies, such as DCS, are critical interfaces with vulnerable children and families; thus, it is imperative the child death review process they implement thoroughly investigate such agencies' interventions with children and families prior to and following deaths and near deaths in order to learn and ultimately improve their ability to support safe outcomes. It was for this reason DCS designed and implemented a new, comprehensive system to examine and learn from the tragedy of the deaths and near deaths of Tennessee children who fall under the responsibility of DCS. With the input of many critical partners, DCS developed the Child Death Response and Review process (CDR process or Child Death Review process), which was implemented on August 29, 2013.

This is the second Annual Report of the CDR process (the Report). The audience for this Report is broad, including DCS' many public and private partners. The Child Death Review process is a pioneering effort to apply a Safety Science approach, which is used successfully in other industries such as aviation, nuclear power and health care to improve safety, to review child deaths and near deaths. As such, it is important for the reader to have a good understanding of the new process, both for this and subsequent years. Therefore, an early section of this Report briefly explains the CDR process. Then the Report moves on to explain what was found, what was recommended, and what action has been taken or will be taken to address those recommendations.

Beginning in 2014 the Department began posting information on custody and non-custody deaths to its website generally within two business days of notification of a child's death. Once a case is closed, the full case file is added. Information on near deaths is posted to the website as it becomes available. This increased transparency means information that typically might be included in an Annual Report is made available to the public long before the CDR process annual report is complete and would be published. Therefore the focus here is less on demographics and, instead, more on what was learned and how the understanding and knowledge can inform DCS practice.

It is important to note a death or near death that occurred in 2014 may not be reviewed until 2015 as a result of the timelines and operational requirements established in the CDR process. Factors that influence when a death is actually reviewed include the time to investigate and

determine if an allegation of abuse or neglect was substantiated[1]. In addition, near deaths require additional time since a physician must review medical records to determine whether the child was in critical or serious medical condition after a case has been closed and substantiated. Further, not all deaths and near-deaths meet criteria for review.

This report covers deaths and near deaths reviewed in Calendar Year, 2014. A total of 141 deaths were reviewed. This includes: 133 non-custody deaths and 8 custody deaths. Of the 133 non-custody deaths, 117 had relevant history within the past three years. During this review period there were 8 near death cases reviewed. This includes 0 custody near deaths and 8 non-custody near deaths. Of the 8 near death cases, 4 had relevant history.

Based on the 149 cases reviewed, 3 key areas of improvement were identified and acted on. These areas of improvement included: coordination between CPS and health units, system variability specific to background checks and system constraints specific to medical record obtainment.

[1] To be more timely with release of the Child Death Review Annual Report, the Department elected to provide this report a month after the end of the first quarter of the calendar year following. The alternative would have been to significantly delay the Annual Report to include all cases from the previous calendar year.

Introduction

As Tennessee's public child welfare agency, DCS is responsible for serving some of the state's most vulnerable citizens. Commissioner Jim Henry was appointed interim Commissioner in February, 2013 and permanent Commissioner in June, 2013. Under his leadership, the mission of DCS is clear: to keep kids safe, get them healthy and get families and their children back on track.

It is estimated that nationally 1,640 children died as a result of abuse or neglect in 2012 (U.S. Department of Health and Human Services, 2013). An important DCS responsibility is to review and learn from the tragedy of child deaths and near deaths in Tennessee. By understanding the complex interplay of human factors and system factors we strive to learn from deaths and near deaths to improve the safety of all children in Tennessee.

Responsibility for review of all child deaths in Tennessee falls to the Department of Health. DCS has a narrower focus and reviews the death or near death of any child in state custody at the time of their death or near death, and deaths and near deaths of any child where there is an allegation of abuse or neglect. A near death is a condition which results from abuse that, as certified by a physician, places the child in serious or critical medical condition. [See TCA §37-5-107(c)(4)].

Moreover, data that are captured elsewhere are not duplicated here. For example, the federal Child Abuse and Prevention Act (CAPTA) requires states to report certain information on a case of abuse or neglect which results in a death or near death. With the posting of child death and near death information, including full case files on the DCS website[2], information beyond that mandated by CAPTA is now provided publicly at: http://www.tennessee.gov/youth/childsafety/publicnotifications.html.

[2] When the Child Death Review process was developed, the Department did not envision providing CAPTA case information online. By providing this information online, the Department is able to more completely and quickly provide the public this information than would be available in an annual report.

History

At the time Commissioner Henry was appointed, the public, the Legislature, and other stakeholders had expressed concerns about DCS' timely and accurate reporting of child fatalities. In addition, a court order issued in the Federal Brian A lawsuit required the Department to develop a revised internal process for investigating child deaths, subject to review and approval of the court monitor (the Technical Assistance Committee) within 90 days from January 24, 2013.

Given the opportunity to revise the child death review process, the Department considered its responsibility to all Tennesseans to be open and transparent about abuse and neglect related deaths and near deaths. Moreover, the Department recognized that transparency requires timely release of information to the public and the Legislature. Therefore DCS designed a Child Death Response and Review process (Child Death Review process or CDR process) that involves a comprehensive, multidisciplinary review of child death and near death cases using a true systems approach to better understand the circumstances surrounding a child death or near death. The systems approach guides reviewers to analyze incidents as emerging from interactions of components and processes within systems. This approach contributes to organizational learning, addressing issues discovered in individual events and understanding the underlying systemic issues that influence adverse outcomes.

Definitions

Custody Death: any child in the state of Tennessee who is in the custody of the DCS at the time of his or her death. All custody deaths will be investigated regardless of allegation of abuse or neglect.

Custody Near Death: any child in the state of Tennessee who is in DCS custody who has a serious or critical medical condition resulting from child abuse or child sexual abuse, as reported by a physician who has examined the child subsequent to the abuse. This is defined in TCA § 37-5-107. The Department has elected to exceed the statutory definition to include more situations as near deaths. As such, the Department will record a near death for a child in custody if the allegation of abuse or neglect is substantiated and a physician reviews the case and determines the child was in a serious or critical medical condition.

Non-Custody Death: any child in the state of Tennessee who is not in DCS custody at the time of death and his or her death is investigated as an allegation of abuse or neglect by DCS.

Non-Custody Near Death: any child in the state of Tennessee who is not in DCS custody who has a serious or critical medical condition resulting from child abuse or child sexual abuse, as reported by a physician who has examined the child subsequent to the abuse. This is defined in TCA § 37-5-107. The Department has elected to exceed the statutory definition to include more situations as near deaths. As such, the Department will record a near death for a child not in custody if the allegation of abuse or neglect is substantiated and a physician reviews the case and determines the child was in a serious or critical medical condition.

Previous History: any Tennessee DCS contact with a child or family occurring within 3 years of the child's death or near death, as documented in the Department's Statewide Automated Child Welfare Information System (SACWIS) reporting system (for DCS this is TFACTS).

Child Death Review Process

Review of a child death or near death begins with the report of the death or near death to the Child Abuse Hotline. Immediately following this report, DCS initiates its Rapid Response process. This protocol ensures that DCS takes immediate action to maintain the safety of other children and family members, notifies appropriate staff and initiates the process of collecting and protecting the integrity of information. As additional information becomes available throughout the investigation, actions or immediate adjustments to existing procedures or protocols may occur to ensure the safety of other children and family members. Specifically, the Department shall immediately take any necessary action so as to assure that children's safety is never taken for granted. Parallel to the rapid response process, the case is tracked to determine if it meets criteria for a death review.

The Child Death Review process has three stages: data collection; the Child Death Review Team (CDRT) meeting; and the development of findings. During the data collection stage, information is derived from factual information contained in records and from interviews of individuals involved in providing care for the subject child or family. The collected data is then presented to the CDRT that conducts a multidisciplinary analysis of the case to be reviewed. Following the CDRT meeting, findings are developed to highlight issues discovered in individual events and to understand the underlying systemic issues that may contribute to adverse outcomes.

Findings are aggregated and reviewed quarterly by the Safety Analysis division. Based on the review of these findings, considerations are developed. Considerations are then reviewed by a CO Safety Action Group[3] to determine if recommendations will be developed based on the consideration. If considerations are approved as recommendations, tracking and implementation is completed by assigned entities. Progress is reviewed by the CO Safety Action Group.

Safety Analysts have a critical role in each of these steps. There are four Safety Analysts across the State of Tennessee, each responsible for one of the child death review regional groupings. The Safety Analyst is responsible for conducting the data collection, which includes technical data and interview data. The Safety Analyst is also responsible for compiling the collected data into a report, which is then presented to the CDRT. As facilitators of the CDRT meeting, the analysts present case information and guide the discussion. Following the CDRT meeting, the Safety Analyst develops findings that are used to inform recommendations.

Also instrumental in the child death review process are the Safety Nurses. Like the Safety Analysts, there are four Safety Nurses across the state of Tennessee, one in each of the child death review regional groupings. The Safety Nurse is responsible for collecting and reviewing all available medical records associated with the subject child. Following this review, a clinical summary is created and added to the report developed by the Safety Analyst. During CDRT

[3] The CO Safety Action Group is a team comprised of Central Office leadership. This group meets quarterly to review considerations derived from CDR findings with the goal of developing and tracking recommendations.

meetings, Safety Nurses are a critical support for CDRT members to understand complex medical information.

Cases Reviewed

Child Death Review Criteria

The Department has established criteria for review of child deaths and near deaths. As such, not all child deaths and near deaths receive a review. The Child Death Review Team reviews deaths and near deaths for:

a. any child in state custody who dies or experiences near death for any reason;
b. any child who has had contact with DCS within the three (3) years preceding their death or near death and their death or near death is being investigated for an allegation of abuse or neglect;
c. any child whose death or near death has been indicated (substantiated) for abuse or neglect regardless of previous contact with DCS;
d. any child death or near death at the direction of the Commissioner, on the advice of the Medical Director or Deputy Commissioner Office of Child Safety.

Cases Reviewed

In this review period, a total of 149 deaths and near deaths were reviewed. This includes: 133 non-custody deaths, 8 non-custody near deaths, 8 custody deaths, and 0 custody near deaths. Cases are reviewed contingent upon meeting criteria for review. Cases are given priority for review by the order in which they meet criteria.

Table 1: Custody Status

Custody Status (n=149)	n	%
Deaths		
Custody	8	6
Non-Custody	133	94
Near Deaths		
Custody	0	0
Non-Custody	8	100

Nearly all (94%; 133 children) reviewed deaths were children not in DCS custody. 8 children (6%) were in DCS custody at their time of death. There were 8 near deaths reviewed in 2014; none of these children were in state custody at the time of the near death incident.

Table 2: History Status of Non-Custody Cases

History Status of Non-Custody Cases (n=141)	n	%
Deaths		
History	117	88
No History	16	12
Near Deaths		
History	4	50
No History	4	50

Of the 133 non-custodial deaths, 88% (117) had applicable DCS history within the past three years. The remaining 12% (16) had no applicable DCS history but were reviewed because the allegation of abuse or neglect directly related to the child's death was substantiated. Of the 8 near deaths reviewed, 50% (4) had applicable DCS history. The remaining 50% (4) did not have applicable DCS history; these cases were reviewed due to a perpetrator's substantiation for abuse or neglect related to the near death incident (e.g. drug-exposure, lack of supervision, etc.).

Regional Information

CDRTs are located within 4 regional groups: West, Middle, Plateau and East. Each regional group consists of 3 DCS regions. Cases are reviewed in the regional group where the child/family was being served. Regional groups are as follows:

1. **West**- Shelby, Northwest, Southwest
2. **Middle**- Mid Cumberland, Davidson, South Central
3. **Plateau**- Upper Cumberland, Tennessee Valley, East
4. **East**- Smoky Mountain, Knox, Northeast

Below are the cases reviewed by regional grouping:

Table 3: Regional Group Information

Regional Group Information (n=149)		
	n	%
Reviews Per CDR Regional Group		
West	47	32
Middle	31	21
Plateau	32	21
East	39	26

A total of 149 deaths and near deaths were reviewed by the Grand Regional Child Death Review Teams. West (comprised of Shelby, Northwest and Southwest) reviewed the most cases, at 47 (32%). East (comprised of Knox, Smoky Mountain and Northeast) reviewed 39 (26%). Plateau (comprised of Tennesse Valley, Upper Cumberland and East) reviewed 32 (21%). Middle (comprised of South Central, Davidson and Mid-Cumberland) reviewed 31 (21%).

Below are the cases reviewed by region:

Table 4: Cases Reviewed by Region

Regional Information (n=149)	n	%
Reviews Per Region		
Davidson	13	9
East	10	7
Knox	7	5
Mid-Cumberland	15	10
Northeast	20	13
Northwest	8	5
Shelby	30	20
South Central	3	2
Southwest	9	6
Smoky Mountain	12	8
Tennessee Valley	12	8
Upper Cumberland	10	7

Shelby had the largest number of reviewed cases (30); Shelby's reviewed deaths and near deaths were 33% higher than the second highest region, Northeast (20). Mid-Cumberland had the third highest number of reviewed cases (15). These three regions held 43.6% of all reviewed cases in 2014. In contrast, South Central had the lowest number of reviewed cases (3), followed by Knox (7), Northwest (8) and Southwest (9). The average number of cases per region was 12.

Demographic Information

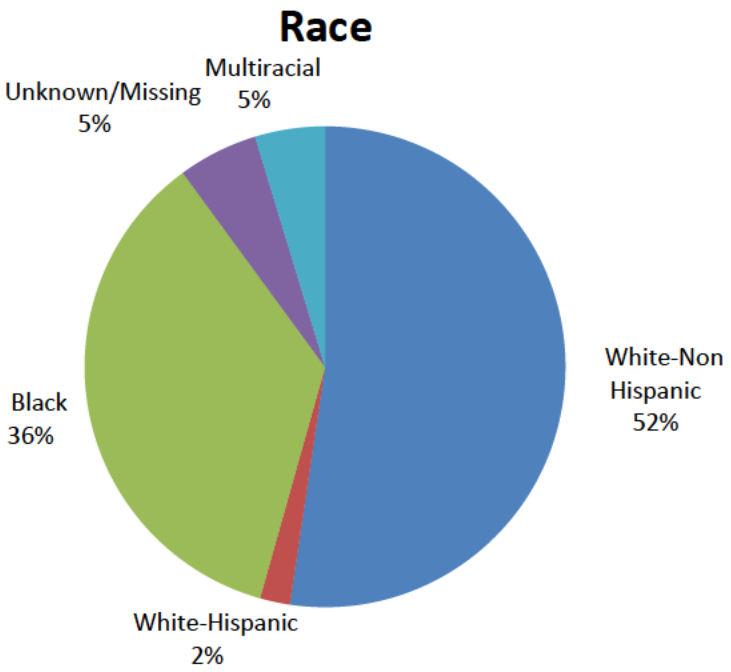
Demographic information is collected from children who have met criteria for a Child Death Review. This demographic information includes race, gender and age. The following table provides demographic information for all cases reviewed within 2014.

Table 5: Demographics

Demographics (n=149)	n	%
Race		
White-Non Hispanic	78	52
White-Hispanic	3	2
Black	53	36
Unknown/Missing	8	5
Multiracial	7	5
Asian	0	0
American Indian	0	0
Other	0	0
Gender		
Male	85	57
Female	64	43
Age		
<6 months	69	46
6 to 11 months	19	13
1 to 5 yrs	30	20
6 to 12 yrs	18	12
≥13 yrs	13	9

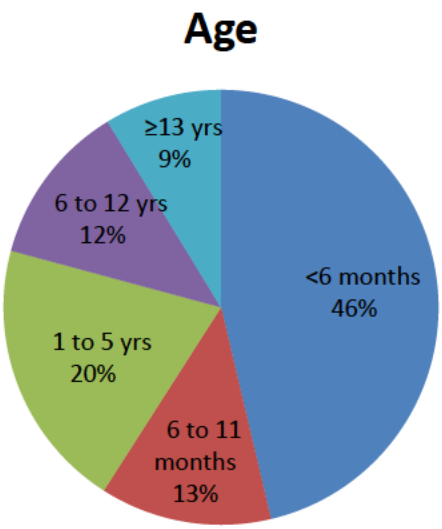
In addition to the demographic information listed above, the department publicly releases all elements designated by the Child Abuse Prevention and Treatment Act (CAPTA) for the child death and near death cases included in this report can be found at the DCS website at the following link http://www.tn.gov/youth/childsafety/publicnotifications.html.

Figure 1: Race



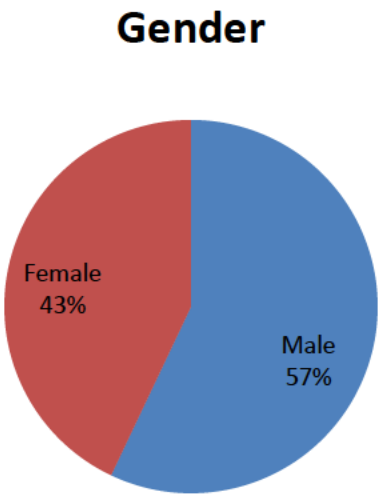
52% (78 children) of reviewed children were White (Non-Hispanic); approximately 2% (3 children) were Hispanic. 36% (53 children) were Black, and 5% (7 children) were identified as bi-racial. The remaining 5% (8 children) were of unknown race. A child's race may be unknown to DCS due to lack of an autopsy, few reviewable medical records, parents' refusal to meet with DCS, etc.

Figure 2: Age



Nearly half (46%; 69 children) of reviewed cases were children less than 6 months of age. Another 13% (19) were children between 6-11 months of age. In total, 59% (88) of cases were circumstances of an infant's death or near death. Next to infants, toddlers (ages 1-5) were the most reviewed age group (20%; 30 children). Generally-speaking, the older a child was, the less likely they were to have circumstances which would precipitate review (i.e. death or near death, applicable history with DCS or perpetrator substantiation).

Figure 3: Gender



Over half (57%; 85 children) of reviewed cases were male children. Females comprised the remaining 43% (64 children).

Table 6: Cause of Death

Cause of Death (n=121)	n	%
Medical (Excludes SIDS, Prematurity, environmental and nutritional neglect)	22	18
Abusive head trauma	5	4
Motorized vehicles	3	2
Weapon/firearm	2	2
Drowning	3	2
Blunt force trauma	8	7
Poisoning/overdose	6	5
Fire/burn	0	0
Inadequate care/neglect (environmental, medical, nutritional)	0	0
Non-accidental trauma	1	1
Sudden Infant Death Syndrome	17	14
Suffocation/Strangulation/Asphyxiation due to unsafe sleeping environment	16	13
Suffocation/Strangulation/Asphyxiation	6	5
Fall injury	0	0
Unable to Determine	22	18
Other	10	8

Of the 141 deaths reviewed, 121 had autopsies completed with results provided to the Department by the writing of this report. Based on these autopsies, 18% (22 children) died of undeterminable cause, and 8% (10) died of "other" causes not readily categorized for the purposes of this report (e.g. deaths related to multiple facets of prematurity, etc.). The remaining 74% of cases had a known and readily categorized cause of death, per autopsy. Of these, more deaths (22%; 19 children) were the result of medical diagnoses than any other cause of death. This category includes children who were the victims of drug-exposure; however, the cause of death was not (per medical evidence) causal to the child's demise. Sudden Infant Death Syndrome resulted in the deaths of 14% (17) of reviewed cases; asphyxiation in unsafe sleep environments was the cause of an infant's death in 16% (13) cases. While the Department investigated more than 13 children found unresponsive or deceased in unsafe sleep environments, only these 13 cases had autopsy results supporting asphyxiation related to unsafe sleep as the cause of death. The remaining deaths (28%) were the result of various causes; no one cause occurred in more than 7% of cases. These causes are as follows: abusive head trauma (4% of cases; 5 children), motorized vehicles (2%; 3), weapon/firearm (2%; 2), drowning (2%, 3), blunt force trauma (7%; 8), poisoning/overdose (5%; 6), non-accidental trauma (1%;1) or asphyxiation (of a child 1+ years of age) (5%; 6). No autopsies confirmed causes of death due to falls/injuries, fire/burns or neglect.

Table 7: Preliminary Cause of Death

Preliminary Cause of Death (n=20)	n	%
Medical (Excludes SIDS, Prematurity, environmental and nutritional neglect)	10	50
Abusive head trauma	1	5
Motorized vehicles	4	20
Weapon/firearm	0	0
Drowning	0	0
Blunt force trauma	1	5
Poisoning/overdose	0	0
Fire/burn	1	5
Inadequate care/neglect (environmental, medical, nutritional)	0	0
Non-accidental trauma	0	0
Sudden Infant Death Syndrome	0	0
Suffocation/Strangulation/Asphyxiation due to unsafe sleeping environment	0	0
Suffocation/Strangulation/Asphyxiation	0	0
Fall injury	0	0
Unable to Determine	0	0
Other	3	15

Of the 141 reviewed deaths, 20 cases either did not receive an autopsy, or the results were not provided to the Department at the writing of this report. Medical personnel from the Department's Office of Child Health were utilized to provide a "preliminary cause of death" for each of these cases. In similarity to Table 6 (above), medical diagnoses caused more deaths (50% of cases; 10 children) than any other category. 15% of cases (3 children) died due to causes not readily captured for the purposes of this report (e.g. deaths related to multiple facets of prematurity, etc.). 20% of cases (4 children) died as a result of accidents involving motorized vehicles. The remaining 15% of cases (3 children) died as a result of one of the following: abusive head trauma (1 child), blunt force trauma (1 child) and fire/burn (1 child).

Table 8: Manner of Death

Manner of Death (n=121)	n	%
Natural	26	21
Accident	27	22
Homicide	15	13
Suicide	4	3
Unable to Determine	49	41

Of the 121 cases that received an autopsy with results provided to the Department by the writing of this report, 59% (72 children) had a determinable manner of death, per autopsy. Accidents accounted for nearly 22% (27) of deaths; unsafe sleep-related deaths are generally captured within this category. 21% (26) of deaths were the result of natural circumstances (i.e. genetic condition, illness, etc.). Sadly 13% (15) of child deaths were the result of homicide, and another 3% (4) were the result of suicide.

Table 9: Preliminary Manner of Death

Preliminary Manner of Death (n=20)	n	%
Natural	12	60
Accident	5	25
Homicide	1	5
Suicide	0	0
Unable to Determine	2	10

Of the 141 reviewed deaths, 20 cases either did not receive an autopsy, or the results were not provided to the Department at the writing of this report. Medical personnel from the Department's Office of Child Health were utilized to provide a "preliminary manner of death" for each of these cases. Over half (60%; 12 children) of these children died of natural circumstances, and 25% (5 children) died through the course of accidents (e.g. motor vehicle collisions, unsafe sleep environments, etc.). 10% (2) did not have a determinable manner of death, and 1 child died as the result of homicide.

Table 10: Cause of Near Death

Cause of Near Death (n=8)	n	%
Medical (Excludes SIDS, Prematurity, environmental and nutritional neglect)	0	0
Abusive head trauma	3	37
Motorized vehicles	1	13
Weapon/firearm	0	0
Drowning	0	0
Blunt force trauma	0	0
Poisoning/overdose	1	13
Fire/burn	0	0
Inadequate care/neglect (environmental, medical, nutritional)	0	0
Non-accidental trauma	0	0
Sudden Infant Death Syndrome	0	0
Suffocation/Strangulation/Asphyxiation due to unsafe sleeping environment	0	0
Suffocation/Strangulation/Asphyxiation	0	0
Fall injury	1	13
Unable to Determine	0	0
Other	2	24

8 near deaths were reviewed. Cause of near death was determined by the Safety Nurses' review of medical records as well as general records in the DCS case file. 25% (2) of near deaths did not have an identifiable cause readily categorized in the selections above; the "other" selection was utilized. Nearly 38% (3) of near deaths were the result of abusive head trauma, making this injury the most common cause of near death in reviewed cases. The remaining near deaths were the result either of either motorized vehicles (1), fall/injury (1) or poisoning/overdose (1).

Table 11: Cause of Death by Custody Status

Cause of Death by Custody Status (n=141)

	Custody	Non Custody	Total
Medical (Excludes SIDS, Prematurity, environmental and nutritional neglect)	3	29	32
Abusive head trauma	0	6	6
Motorized vehicles	0	7	7
Weapon/firearm	0	2	2
Drowning	0	3	3
Blunt force trauma	1	8	9
Poisoning/overdose	1	5	6
Fire/burn	0	1	1
Inadequate care/neglect (environmental, medical, nutritional)	0	0	0
Non-accidental trauma	0	1	1
Sudden Infant Death Syndrome	0	17	17
Suffocation/Strangulation/Asphyxiation due to unsafe sleeping environment	0	16	16
Suffocation/Strangulation/Asphyxiation	3	3	6
Fall injury	0	0	0
Unable to Determine	0	22	22
Other	0	13	13
Total	8	133	141

Table 12: Manner of Death by Custody Status

Manner of Death by Custody Status (n=141)

	Custody	Non Custody	Total
Natural	3	35	38
Accident	1	31	32
Homicide	1	15	16
Suicide	3	1	4
Unable to Determine	0	51	51
Total	8	133	141

Table 13: Cause of Death by Age

Cause of Death by Age (n=141)

	<6 months	6 to 11 months	1 to 5 yrs	6 to 12 yrs	≥13 yrs	Total
Medical (Excludes SIDS, Prematurity, environmental and nutritional neglect)	9	4	5	9	5	32
Abusive head trauma	2	2	2	0	0	6
Motorized vehicles	1	0	3	2	1	7
Weapon/firearm	0	0	0	2	0	2
Drowning	0	1	0	2	0	3
Blunt force trauma	0	1	8	0	0	9
Poisoning/overdose	1	0	1	0	4	6
Fire/burn	0	0	1	0	0	1
Inadequate care/neglect (environmental, medical, nutritional)	0	0	0	0	0	0
Non-accidental trauma	0	0	1	0	0	1
Sudden Infant Death Syndrome	15	2	0	0	0	17
Suffocation/Strangulation/Asphyxiation due to unsafe sleeping environment	13	2	1	0	0	16
Suffocation/Strangulation/Asphyxiation	0	1	1	1	3	6
Fall injury	0	0	0	0	0	0
Unable to Determine	17	3	2	0	0	22
Other	8	3	1	1	0	13
Total	66	19	26	17	13	141

Table 14: Manner of Death by Age

Manner of Death by Age (n=141)

Age	Natural	Accident	Homicide	Suicide	Unable to Determine	Total
<6 months	13	12	3	0	38	66
6 to 11 months	7	3	3	0	6	19
1 to 5 yrs	6	8	9	0	3	26
6 to 12 yrs	7	7	1	0	2	17
≥13 yrs	5	2	0	4	2	13
Total	38	32	16	4	51	141

Debriefings

In addition to the factual data collected specific to the case being reviewed, debriefings are conducted with frontline staff and supervisors involved with the subject case. These debriefings explain actions, decisions and provide a comprehensive understanding of case context. Additionally, debriefings promote a safe environment for staff to revisit cases with Safety Analysts and review their work. This provides critical learning opportunities for all staff involved. This is achieved through a robust process.

Debriefings are conducted by the Safety Analysts to help reconstruct the situation that surrounded frontline workers while trying to provide services to children and families (Dekker, 2006). Gary Klein developed a method of interviewing (as cited in Dekker, 2006, pp.94-95), outlined below:

1. Have the participant tell the story from their point of view, without the Safety Analyst presenting any additional information that may distort their memory.
2. The Safety Analyst tells the story back to the participant, in an attempt to gain common ground.
3. The Safety Analyst along with the participant identify critical junctures in the sequence of events (this includes issues identified from technical data) if anything additional is detected.
4. The Safety Analyst progressively probes critical junctures to show how the situation was understood from the perspective of the participant; at this critical time, it may be appropriate to provide any necessary technical data to the participant.

At the critical junctures identified in numbers 3 and 4 above, the Safety Analyst identifies:

1. What cues may have prompted decisions or actions from the participant's perspective.
2. What knowledge (training, previous learning, experience, etc.) was utilized to inform these decisions or actions.
3. What the expectations were about how a particular plan was going to develop.
4. What other influences or constraints (situational, operational, and organizational) may have influenced their perception of a situation and subsequent actions.

In 2014, 348 debriefings were conducted. During these debriefings, 625 different findings were discussed. The collection of information obtained is then further analyzed for common themes.

Table 15: Regional Debriefings

Region	Debriefings	Findings
West	68	107
Middle	71	168
Plateau	76	144
East	133*	206
Total	348	625

*Increased amount of debriefings due to reviews of children in custody.

Findings

Represented below is this year's distribution of themes. Themes have specific definitions developed from relevant safety science literature. Using these definitions, themes are then identified within and then across cases. The frequency of the theme is determined by the amount of times it is identified across cases. The frequency of themes informs further analysis designed to identify specific learning points. Below is the list of themes with corresponding definitions.

Cognitive Fixation: A faulty understanding of a situation due to biases (e.g., confirmation bias, focusing effect, transference).

Demand-Resource Mismatch: A lack of resources (e.g., human, capital) to carry out safe work practices.

Documentation: Absent or ineffective documentation in connection with a particular case.

Equipment/Technology: An absence or deficiency in the equipment and technology utilized to carry out work practices.

Knowledge Deficit: An absence of knowledge or difficulties activating knowledge (putting it into practice).

Medical Records: Difficulties in obtaining, understanding and utilizing medical record or autopsy information.

Policies: The absence or ineffectiveness of a policy.

Production Pressure: Demands to increase efficiency, which are incompatible with safety assurance.

Service Array: The availability of a particular service which could support safe environments for children and families.

Stress: Unsafe work practices influenced by stress.

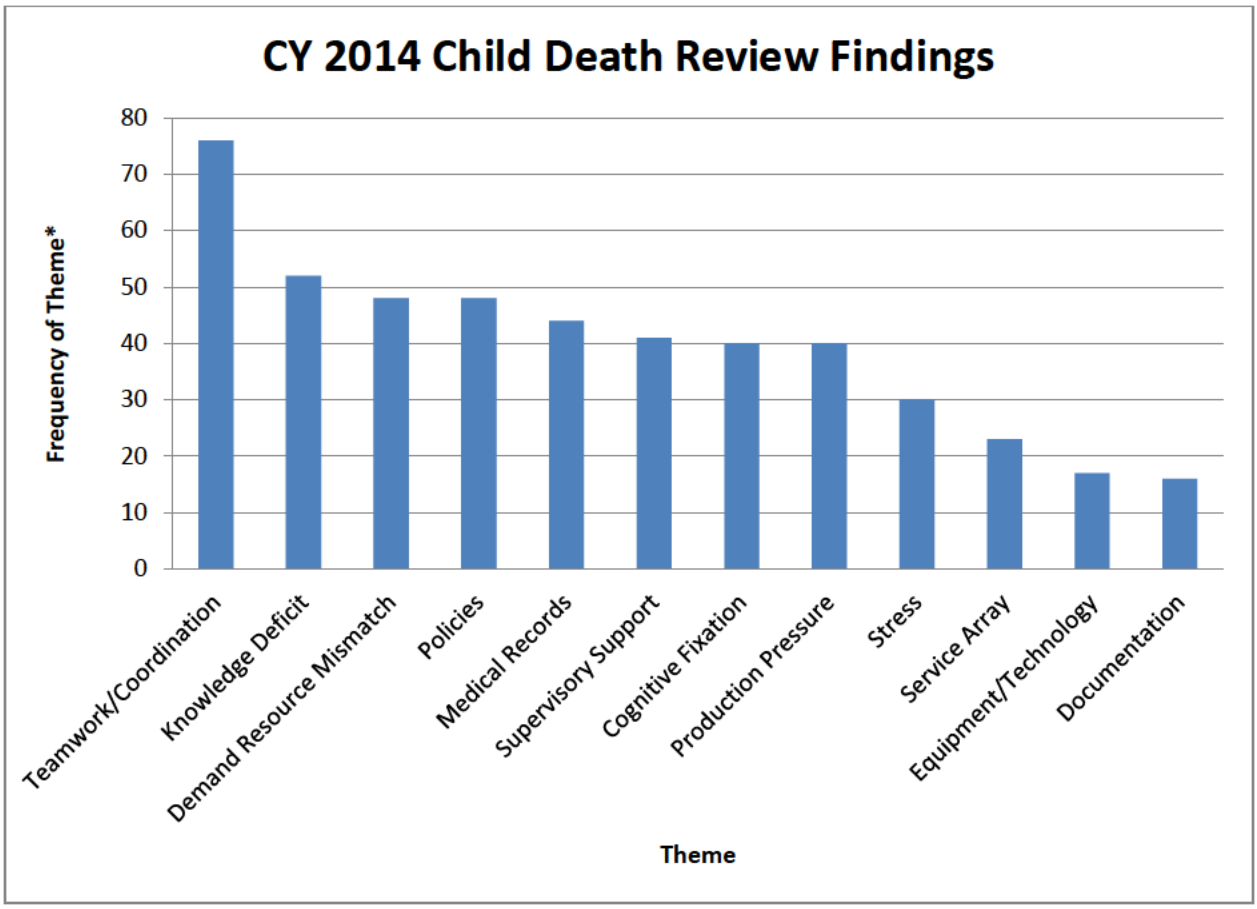
Supervisory Support: Ineffective support or knowledge transfer from a supervisor to those supervised.

Teamwork/Coordination: Ineffective collaboration between two or more entities (e.g., agencies, people and teams).

These themes are identified within and across reviewed cases with the use of the Systems Analysis Communimetric Tool. The Systems Analysis Communimetric Tool is a multi-purpose information integration tool whose purpose is to support a culture of safety, improvement and resilience. Completion of the instrument is accomplished in order to allow for the effective quantifiable communication of influencing factors on a case at all levels of the system. Themes found within cases are scored. These scores reflect whether a finding was present in a case and supported by evidence, which is captured by the label "actionable."

Below are findings from all cases:

Figure 4: Child Death Review Findings



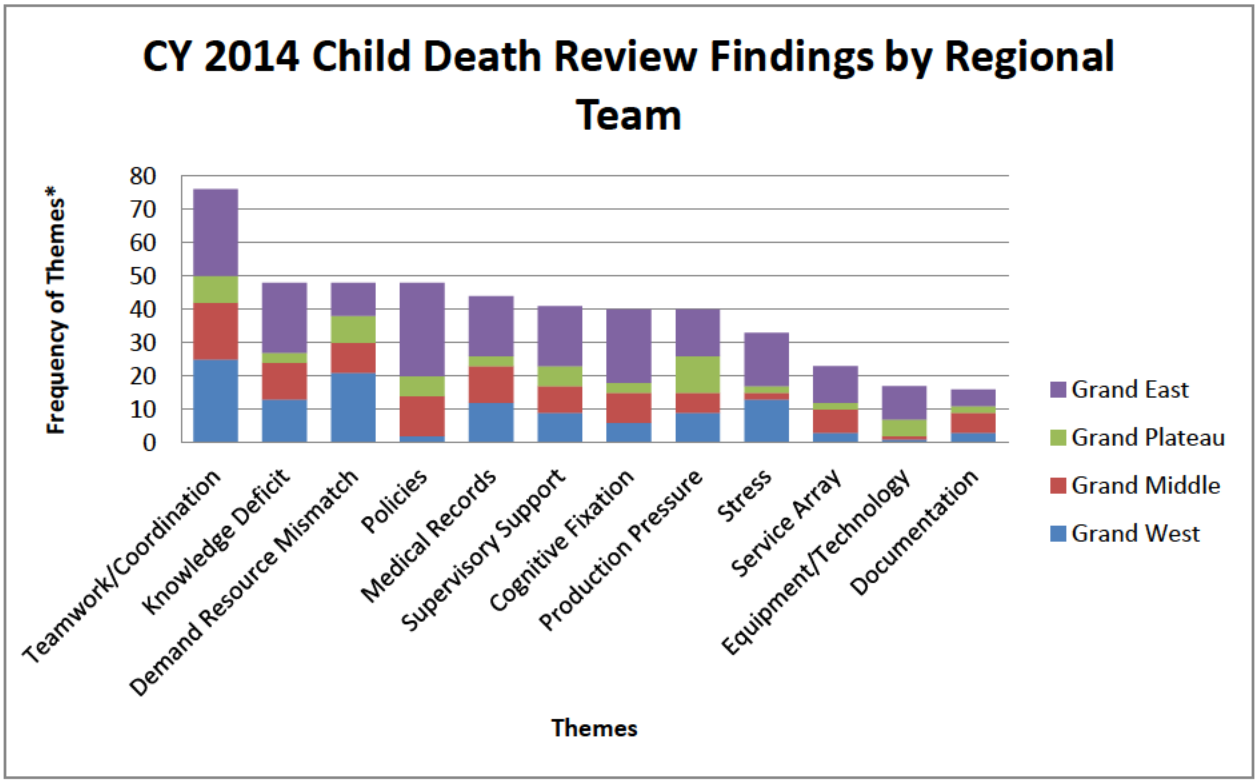
*The frequency of each system level theme is determined by the amount of times it is identified as actionable across Child Death Review cases. A theme cannot be counted more than once for any single case.

Teamwork/Coordination was, by far, the item that scored actionable at the highest rate with 51% of all reviewed cases scoring actionable. Of the remaining top 4 categories (Knowledge Deficit, Demand-Resource Mismatch, Policies, and Medical Records) between 30% and 35% of all cases reviewed scored actionable on these items. And amongst Supervisory Support, Cognitive Fixation and Production Pressure, between 26% and 28% of all reviewed cases scored actionable on these items. Rounding out the lower end of the CDR tool items, less than a

quarter of all reviewed cases statewide scored actionable on Stress, Service Array, Equipment/Technology and Documentation.

Below are findings distributed by regional teams:

Figure 5: Child Death Review Findings by Regional Team



*The frequency of each system level theme is determined by the amount of times it is identified as actionable across Child Death Review cases. A theme cannot be counted more than once for any single case.

This graph depicts the contribution of each Grand Region's cases to the total number of cases scoring actionable for each CDR tool item. The total number of cases reviewed statewide equaled 149. Of those, 47 cases came out of Grand West, 31 cases came out of Grand Middle, 31 cases came out of Grand Plateau, and 40 cases came out of Grand East. Of the top highest actionable items, the following trends are noted:

- For Teamwork/Coordination, fairly equal numbers of cases reviewed in Grand West (25 of 47) and Grand Middle (17 of 31) regions scored actionable. Grand East had significantly more cases scoring actionable on this item (26 of 39) while Grand Plateau had significantly less (8 of 32)
- For Knowledge Deficit, over half of Grand East region's cases (21 of 39) scored actionable on this item. Additionally, 11 of Grand Middle's 31 cases scored actionable on this item. Comparatively, Grand Plateau and Grand West were less represented on this item (7 of 32 cases scoring actionable from Grand Plateau and 13 of 47 cases scoring actionable for Grand West).

- For Demand-Resource Mismatch, Grand West region's cases comprised 21 of the 48 total cases that scored actionable on this item (a total of 21 of Grand West's 47 total cases reviewed). Interestingly, this item did not score in the top 4 items for either the Grand East or the Grand Middle regions.
- Over half of the cases that scored actionable on Policies came out of the Grand East region (28 of the 48 total). This also depicts that over half of Grand East's total cases reviewed (28 of 40) scored actionable on this item. Conversely, Policies was not even in the top four actionable items for Grand West Region, with Grand West only having 2 of its 47 total cases score actionable on this item.
- Medical Records seemed fairly evenly represented by Grand East, Grand Middle and Grand West regions and underrepresented by Grand Plateau Region. Interestingly, this item only made the top 4 actionable items for the Grand Middle region.

Learning and improving DCS's systems are a primary focus of the Child Death Review. DCS conducts reviews in order to understand how children and families can be better supported to eliminate or reduce the likelihood of these tragic outcomes. Through this understanding, the Department learns how it can support children and families in the future to keep children safe, healthy and ensure they are back on track. The following were significant learning points from the review of deaths and near deaths in this review period:

1) CPS investigation and assessment staff are often confronted with complex medical issues. When trying to identify the presence of an issue, case managers were making decisions based on current knowledge and without the guidance of medical professionals. Additionally, participants were noted to be unaware of all the medical resources that existed in their region, such as technical assistance to understand mental health information. *Example: A youth died of complications stemming from diabetes; he and his caretakers were chronically non-compliant with medical directives. Throughout years of CPS cases, the Department of Children's Services (DCS) Well-Being Unit was not engaged to assess and provide medically-informed service recommendations for the family.*

2) Frontline staff constantly identify risk factors that influence their plans of safety. Risks that may turn up on a background check can be an important factor in complex decisions, such as if a child needs to be removed from an unsafe environment. Analysis and CDRT review revealed regional variability in the way background checks are administered and used to inform casework. Influences included; checks limited to county of residence; 2) uncertainty over whom in the home should be checked; and 3) lack of clear actions steps associated with background check results. *Example: While investigating an allegation of physical abuse, the CPSI did not conduct background checks on all adults in home, only the AP.*

3) Frontline CPS workers are tasked with making informed decisions to ensure appropriate medical care for children. For many complex medical cases, these decisions may need to be informed by medical records specific to the child. Frontline workers have experienced difficulty obtaining medical records protected by HIPAA because the process is cumbersome due to provider inconsistencies, difficulty with adequately using the release of information form and inadequate knowledge of how to obtain records in absence of having a release form. When CPS staff experience difficulty requesting records, the likelihood of receiving medical records late or not at all increases. *Example: CPSI experienced difficulty requesting medical information specific to their case, which resulted in delayed acquisition.*

Recommendations

Recommendations are informed by what is learned from the Child Death Review process. With the support of the CO Safety Action Group, recommendations are developed and tracked. Based on the findings, recommendations for improved practice are as follows:

1) Define the scope of services that Health units across the state will provide to CPS workers.

2) Identify what services are available to support CPS workers while carrying out casework and when they can be accessed.

3) Follow up on the effectiveness of a background check memo sent out recently to all DCS staff.

4) Standardize release of information process for medical records requested by CPS staff.

5) Develop curriculum to support the effective collection and use of medical records.

Department Actions

The development of action plans for recommendations are completed outside of the CO Safety Action Group. Recommendations are presented to CQI teams comprised of content experts specific to the recommendation. These specific teams identify actions that will be implemented and tracked. These actions include:

1) To address recommendation 1, the Office of Child Health has taken steps to define the scope of practice for Health Units in the regions. This was accomplished by a retreat which occurred April 1st-2nd, 2015. During the retreat, different areas within the Health Units (e.g., nursing, psychology) met together and separately to clearly define a scope of services and supports provided to frontline staff and ways to improve.

2) To address recommendation 2, a team was developed using content experts (e.g., health unit staff, CPS case managers, CQI staff). The team used the CQI process to deconstruct the recommendations into actionable items. Following the development of action steps, the CQI division monitored implementation and provided status updates on progress to the CDR CQI team. Additionally, a survey was released to all CPS frontline staff and supervisors in November 2014. Based on information received from this survey a website is being developed to highlight each division within the Office of Child Health and will be available July, 2015.

3) To address recommendation 3, the Office of Child Safety will review a previously distributed memo regarding background checks with the Policy and Practice group. This will be done to obtain feedback on the quality of clarification and if more or less direction is desired on this issue. Additionally, the finding will be reviewed at the April 2015 Regional Administrator meeting to determine their impressions on this issue. Lastly, the Office of Child Safety will ensure that clarification on background checks is incorporated into policy.

4) To address recommendations 4, a CQI team will be developed to deconstruct the release of information process to identify areas for standardization and develop a comprehensive list of medical records to be requested.

5) To address recommendation 5, CQI will collaborate with Legal and CPS to develop a training curriculum to support the effective collection and use of medical records.

References

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